



## RISK MANAGEMENT DEPARTMENT

Fort Bend County, Texas

Wyatt O. Scott  
Director

Phone: 281-341-8630  
Fax: 281-341-3751

TO: Debbie Kaminski  
Purchasing Agent

FROM: Wyatt Scott  
Director of Risk Management

DATE: July 31, 2017

SUBJECT: 2018 Benefit Vendor Agreement Renewals

The following benefit vendors have offered to continue their services for the 2018 benefit year with no increases in rates or administration fees (supporting documents attached, of note, Humana vision for current year was quoted last year with a two year rate guarantee. The attached document supports that 2018 will be year two of the original quote):

- Humana for CompDent and Humana Vision 130
- Unum for Long Term Disability and Basic Life/AD&D

Risk Management recommends renewing all of the proposed benefits.

Please submit these renewals to Commissioners Court for approval at the next Commissioners Court meeting.

Thank you,

Wyatt Scott  
Director of Risk Management



Your new rates for the next benefit period are as follows:

1/1/2017 Effective Date with a 2 year Rate Guarantee Period: 1/1/2017 - 12/31/2018

	<b>Current Plan (Discontinued*)</b>	<b>New Plan</b>
Plan Name:	VCP	Humana Vision 130
Exam Copay (In):	\$10	\$10
Materials Copay (In):	\$15	\$15
Frame Allowance (In):	\$50	\$130
Contact Lens Allowance (In):	\$105	\$130
Frequency (In):	12/12/24	12/12/24
	<b>Current Monthly Rates</b>	<b>New Monthly Rates</b>
Employee Only:	\$6.92	\$7.27
Employee & Spouse:	\$13.80	\$14.49
Employee & Child(ren):	\$13.10	\$13.76
Employee & Family:	\$23.18	\$24.34

\*You should have received a letter from Humana notifying you that your current plan is being discontinued

Vision care services	If you use an IN-NETWORK provider (Member cost)	If you use an OUT-OF-NETWORK provider (Reimbursement)
Exam with dilation as necessary • Retinal imaging <sup>1</sup>	\$10 Up to \$39	Up to \$30 Not covered
Contact lens exam options <sup>2</sup> • Standard contact lens fit and follow-up • Premium contact lens fit and follow-up	Up to \$55 10% off retail	Not covered Not covered
Frames <sup>3</sup>	Up to \$130 20% off balance over \$130	Up to \$65
Standard plastic lenses <sup>4</sup> • Single vision • Bifocal • Trifocal • Lenticular	\$15 \$15 \$15 \$15	Up to \$25 Up to \$40 Up to \$60 Up to \$100
Covered lens options <sup>4</sup> • UV coating • Tint (solid and gradient) • Standard scratch-resistance • Standard polycarbonate - adults • Standard polycarbonate - children <19 • Standard anti-reflective coating • Premium anti-reflective coating - Tier 1 - Tier 2 - Tier 3 • Standard progressive (add-on to bifocal) • Premium progressive - Tier 1 - Tier 2 - Tier 3 - Tier 4 • Photochromatic / plastic transitions • Polarized	\$15 \$15 \$15 \$40 \$40 \$45 Premium anti-reflective coatings as follows: \$57 \$68 80% of charge \$15 Premium progressives as follows: \$110 \$120 \$135 \$90, 80% of charge, then up to \$120 \$75 20% off retail	Not covered Not covered Not covered Not covered Not covered Not covered Premium anti-reflective coatings as follows: Not covered Not covered Not covered Up to \$40 Premium progressives as follows: Not covered Not covered Not covered Not covered Not covered Not covered Not covered
Contact lenses <sup>5</sup> (applies to materials only) • Conventional  • Disposable • Medically necessary	Up to \$130, 15% off balance over \$130 Up to \$130 \$0	Up to \$104  Up to \$104 Up to \$200

## Humana Vision 130

### Vision care services

	<b>If you use an IN-NETWORK provider (Member cost)</b>	<b>If you use an OUT-OF-NETWORK provider (Reimbursement)</b>
<b>Frequency</b>		
• Examination	Once every 12 months	Once every 12 months
• Lenses or contact lenses	Once every 12 months	Once every 12 months
• Frame	Once every 24 months	Once every 24 months

### Diabetic Eye Care: care and testing for diabetic members

• Examination - Up to (2) services per year	\$0	Up to \$77
• Retinal Imaging - Up to (2) services per year	\$0	Up to \$50
• Extended Ophthalmoscopy - Up to (2) services per year	\$0	Up to \$15
• Gonioscopy - Up to (2) services per year	\$0	Up to \$15
• Scanning Laser - Up to (2) services per year	\$0	Up to \$33

### Optional benefits

- <sup>1</sup> Member costs may exceed \$39 with certain providers. Members may contact their participating provider to determine what costs or discounts are available.
- <sup>2</sup> Standard contact lens exam fit and follow up costs and premium contact lens exam discounts up to 10% may vary by participating provider. Members may contact their participating provider to determine what costs or discounts are available.
- <sup>3</sup> Discounts available on all frames except when prohibited by the manufacturer.
- <sup>4</sup> Lens option costs may vary by provider. Members may contact their participating provider to determine if listed costs are available.
- <sup>5</sup> Plan covers contact lenses or frames, but not both, unless you have the Eye Glass and Contact Lens Rider.

### Additional plan discounts

- Member may receive a 20% discount on items not covered by the plan at network Providers. Members may contact their participating provider to determine what costs or discounts are available. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Services or materials provided by any other group benefit plan providing vision care may not be covered. Certain brand name Vision Materials may not be eligible for a discount if the manufacturer imposes a no-discount practice. Frame, Lens, & Lens Option discounts apply only when purchasing a complete pair of eyeglasses. If purchased separately, members receive 20% off the retail price.
- Members may also receive 15% off retail price or 5% off promotional price for LASIK or PRK from the US Laser Network, owned and operated by LCA Vision. Since LASIK or PRK vision correction is an elective procedure, performed by specialty trained providers, this discount may not always be available from a provider in your immediate location.

## Limitations and Exclusions:

In addition to the limitations and exclusions listed in your "Vision Benefits" section, this policy does not provide benefits for the following:

1. Any expenses incurred while you qualify for any worker's compensation or occupational disease act or law, whether or not you applied for coverage.
2. Services:
  - That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
  - Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
  - Furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
3. Any loss caused or contributed by:
  - War or any act of war, whether declared or not;
  - Any act of international armed conflict; or
  - Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment.
6. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
7. Prescription drugs or pre-medications, whether dispensed or prescribed.
8. Any service not specifically listed in the Schedule of Benefits.
9. Any service that we determine:
  - Is not a visual necessity;
  - Does not offer a favorable prognosis;
  - Does not have uniform professional endorsement; or
  - Is deemed to be experimental or investigational in nature.
10. Orthoptic or vision training.
11. Subnormal vision aids and associated testing.
12. Aniseikonic lenses.
13. Any service we consider cosmetic.
14. Any expense incurred before your effective date or after the date your coverage under this policy terminates.
15. Services provided by someone who ordinarily lives in your home or who is a family member.
16. Charges exceeding the reimbursement limit for the service.
17. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
18. Plano lenses.
19. Medical or surgical treatment of eye, eyes, or supporting structures.
20. Replacement of lenses or frames furnished under this plan which are lost or broken, unless otherwise available under the plan.
21. Any examination or material required by an Employer as a condition of employment.
22. Non-prescription sunglasses.
23. Two pair of glasses in lieu of bifocals.
24. Services or materials provided by any other group benefit plans providing vision care.
25. Certain name brands when manufacturer imposes no discount.
26. Corrective vision treatment of an experimental nature.
27. Solutions and/or cleaning products for glasses or contact lenses.
28. Pathological treatment.
29. Non-prescription items.
30. Costs associated with securing materials.
31. Pre- and Post-operative services.
32. Orthokeratology.
33. Routine maintenance of materials.
34. Refitting or change in lens design after initial fitting, unless specifically allowed elsewhere in the certificate.
35. Artistically painted lenses.

## Vision health impacts overall health

Routine eye exams can lead to early detection of vision problems and other diseases such as diabetes, hypertension, multiple sclerosis, high blood pressure, osteoporosis, and rheumatoid arthritis<sup>1</sup>.

<sup>1</sup> Thompson Media Inc.

## Questions

Check out [Humana.com](http://Humana.com)

Call 1-866-995-9316 seven days a week: 8 a.m. to 6 p.m. Eastern Time Monday through Saturday, and 11 a.m. to 8 p.m. Sunday.

Humana Vision products insured by Humana Insurance Company, Humana Health Benefit Plan of Louisiana, The Dental Concern, Inc. or Humana Insurance Company of New York.

This is not a complete disclosure of the plan qualifications and limitations. Specific limitations and exclusions as contained in the Regulatory and Technical Information Guide will be provided by the agent. Please review this information before applying for coverage.

**NOTICE:** Your actual expenses for covered services may exceed the stated cost or reimbursement amount because actual provider charges may not be used to determine insurer and member payment obligations.

**Humana**<sup>®</sup>



**Humana.**

## **Important dental plan information**

As you have been made aware through this renewal experience, Humana is offering new dental plans. In order to fulfill our contractual obligations official notice regarding the discontinuance of the current dental plan will take place 90 days before the actual renewal date. Notification will be sent directly to the agent and the group. The dental product discontinuance communication will not impact the results of this renewal. However, if you would like to consider other Humana dental plan options, please do not hesitate to contact your agent or your Humana Sales Associate.

GCHJEA3EN



July 14, 2017

Fort Bend County

Your new rates for the next benefit period are as follows:

Effective Date and Rate Guarantee Period: January 1, 2018 - December 31, 2018

	<b>Current Plan</b>	<b>Recommended New Plan</b>
Plan Name:	CS600	CS600
Perio/Endo:	N/A	N/A
Deductible (In/Out):	N/A	N/A
Annual Maximum:	N/A	N/A
Optional Benefits:	N/A	N/A
	<b>Current Monthly Rates</b>	<b>New Monthly Rates</b>
Employee Only:	\$10.98	\$10.98
Employee & Spouse:	\$20.00	\$20.00
Employee & Child(ren):	\$21.32	\$21.32
Employee & Family:	\$29.84	\$29.84

\*You should have received a letter from Humana notifying you that your current plan is being discontinued.



# CERTIFICATE OF INTERESTED PARTIES

FORM 1295

1 of 1

Complete Nos. 1 - 4 and 6 if there are interested parties.  
Complete Nos. 1, 2, 3, 5, and 6 if there are no interested parties.

**OFFICE USE ONLY  
CERTIFICATION OF FILING**

**1 Name of business entity filing form, and the city, state and country of the business entity's place of business.**  
Humana Insurance Company  
De Pere, WI United States

**Certificate Number:**  
2017-219408

**Date Filed:**  
06/06/2017

**2 Name of governmental entity or state agency that is a party to the contract for which the form is being filed.**  
Fort Bend County

**Date Acknowledged:**  
09/05/2017

**3 Provide the identification number used by the governmental entity or state agency to track or identify the contract, and provide a description of the services, goods, or other property to be provided under the contract.**  
772647 and 5274  
Vision and Dental

4	Name of Interested Party	City, State, Country (place of business)	Nature of interest (check applicable)	
			Controlling	Intermediary

**5 Check only if there is NO Interested Party.**

**6 AFFIDAVIT** I swear, or affirm, under penalty of perjury, that the above disclosure is true and correct.

\_\_\_\_\_  
Signature of authorized agent of contracting business entity

AFFIX NOTARY STAMP / SEAL ABOVE

Sworn to and subscribed before me, by the said \_\_\_\_\_, this the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_, to certify which, witness my hand and seal of office.

\_\_\_\_\_  
Signature of officer administering oath      Printed name of officer administering oath      Title of officer administering oath

# CERTIFICATE OF INTERESTED PARTIES

FORM 1295

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Complete Nos. 1 - 4 and 6 if there are interested parties.  
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## OFFICE USE ONLY CERTIFICATION OF FILING

Certificate Number:  
2017-219749

Date Filed:  
06/06/2017

Date Acknowledged:

**1 Name of business entity filing form, and the city, state and country of the business entity's place of business.**

CompBenefits Insurance Company  
Houston, TX United States

**2 Name of governmental entity or state agency that is a party to the contract for which the form is being filed.**

Fort Bend County

**3 Provide the identification number used by the governmental entity or state agency to track or identify the contract, and provide a description of the services, goods, or other property to be provided under the contract.**

5274  
Group Dental Insurance

4	Name of Interested Party	City, State, Country (place of business)	Nature of interest (check applicable)	
			Controlling	Intermediary

**5 Check only if there is NO Interested Party.**



**6 AFFIDAVIT**

I swear, or affirm, under penalty of perjury, that the above disclosure is true and correct.



*Richard D. Remmers*  
Signature of authorized agent of contracting business entity

Richard D. Remmers, Vice  
President, Group Segment

AFFIX NOTARY STAMP / SEAL ABOVE

Sworn to and subscribed before me, by the said Richard D. Remmers, this the 6th day of June, 2017, to certify which, witness my hand and seal of office.

*Rebecca King French*  
Signature of officer administering oath

Rebecca King French  
Printed name of officer administering oath

Notary Public  
Title of officer administering oath

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Signature of officer administering oath      Printed name of officer administering oath      Title of officer administering oath